STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505291	A. BUILDING _____ B. WING _____	08/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW LUTHERAN CARE CENTER	1841 EAST UPRIVER DRIVE SPOKANE, WA 99207

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This report is the result of an unannounced Quality Indicator Survey conducted at Riverview Lutheran Care Center on 7/31/13, 8/01/13, 8/02/13, 8/05/13, and 8/06/13. A sample of 28 residents was selected from a census of 54. The sample included 17 current residents and the records of 11 former and/or discharged residents.

The survey was conducted by:

[redacted]SW
[redacted]N
[redacted]RN
[redacted]RN
[redacted], MSW
[redacted]hi Shea, RN

The survey team is from:

Department of Social & Health Services
Aging & Long Term Support Administration
Residential Care Services, District 1, Unit A
316 W. Boone Avenue Suite 170
Spokane, Washington 99201-2351

Telephone: (509)323-7302
Fax: (509)329-3993

8/19/13
Residential Care Services — Date

Riverview Lutheran Care Center takes great pride in giving above and beyond quality care. Our number one priority is serving our residents and their families. We take each citation seriously and address concerns quickly and appropriately. We thank the survey team for working with us and helping us toward becoming a better nursing home for our current and future residents. We will continue to provide outstanding quality care.

RECEIVED
AUG 27 2013
DSHS ADSA RCS
SPOKANE WA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure resident's privacy for 2 residents, (#2 and #7) in a sample of 28 when entering resident's room and providing care for residents. Findings include: During an interview on 7/31/13 at 3:20 p.m.,	F 164	F164 The nursing home will correct the deficiency as it relates to the resident and will act to protect other residents in similar situations. This will be done through re-in servicing all staff on current personal privacy policies and procedures. Hall observation audits will take place weekly over a one month duration for the purpose of monitoring performance and ensuring solutions are sustained. This will make certain that our current privacy policy is continued to be followed. This corrective action will be completed by 9/16/13. The Director of Nursing will be responsible for ensuring the correction.	

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F 164	Continued From page 2 Resident #2 reported she had to remind the staff frequently to pull the drape closed to provide her privacy when she would receive assistance for dressing and cares. During an observation on 7/31/13 at 1:45 p.m., Staff #G was observed entering Resident #7's room without knocking or stating who was entering. During an observation on 8/5/13 at 2:20 p.m., Staff #H was observed entering Resident #2 room without knocking or stating who was entering the room. During an interview on 8/6/13 at 8:49 a.m., Staff #I reported the policy to enter a resident's room would be to knock first, let the resident know who you are and let the resident know what you are going to do. Staff were aware of the facility's policy for privacy and there were multiple staff members who were observed entering resident rooms without knocking and identifying self to resident. Resident #2 felt she needed to remind staff to close her curtains so she could be ensured privacy when getting assistance for personal cares. The facility was unable to ensure residents rights to privacy.	F 164		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	F 166	F166 The nursing home will correct the deficiency as it relates to the	

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F 166	Continued From page 3 review it was determined the facility failed to promptly resolve a residents grievance and provide follow up for 1 resident (#2) in a sample of 28 resident's, by not following up with the resident and family when a grievance was brought to the staff's attention. The facility was unable to communicate the grievance of the resident to provide a resolution to meet the needs of the resident. Findings include: During an interview on 7/31/13 at 3:20 p.m. the resident reported she felt the facility staff was not listening to her needs and did not follow up accordingly involving an incident with a nursing aide. The resident reported she was upset with an interaction between her and a nursing aide who assisted her in getting dressed a week prior. The resident stated the nursing aide provided her with a pair of pants from her closet and she told the nursing aide they were not her pants. The nursing aide continued to put the pants on the resident which were too tight and ended up ripping. The resident stated the nursing aide said "You will have to wear them this way" and the resident wore a blanket around her to cover the unfitting pants. The resident reported this did not make her feel she was being listened to and was hesitant to share the incident with other staff since she felt they would not do anything about it. The resident reported the staff that assisted her with the pants knew she was upset. The resident expressed her family takes care of the things she needs so she wants them to be notified. The resident reported there was no follow up after the incident had occurred. During an interview on 8/5/13 at 10:30 a.m., Staff #E reported the resident had complained about staff not listening to her previously in	F 166	resident and protect residents in similar situations by educating and counseling the employee involved and by taking appropriate disciplinary action. The facility will construct a grievance policy and procedure. The new grievance policy and procedure will include a log book for residents, families, and staff to file grievances. This will allow the facility to demonstrate follow through and resolution to the grievance filed. Also, the facility will in service all staff regarding the new grievance policy and procedure. This corrective action will be completed by 9/16/13. The Director of Nursing will be responsible for ensuring this correction.	

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F 166	Continued From page 4 regards to other issues. Staff #E reported if a concern came from a resident then Staff #E would go to a charge nurse or Director of Nursing and they would deal with it. Staff #E reported not being aware of any issues with the resident in regards to her pants not fitting and the resident getting upset with staff. During an interview on 8/5/13 at 1:45 p.m., Staff #C confirmed she had assisted the resident with dressing the day of the incident with the pants. Staff #C reported she was the residents nursing aide on this day and had worked with her several times since the incedent with the pants. During an interview on 8/5/13 at 2:15 p.m., Family member #1 had returned a call to a nurse days after the incident in regards to another issue and asked the nurse what was the outcome of the residents concern since she was surprised she had not received a call in regards to this incident. Family member #1 was told by a nurse, the nursing aide (Staff #C) that worked with the resident that day would no longer be working with the resident and the pants where the roommates which would be replaced. During an interview on 8/6/13, family member #2 reported she came to visit the resident the day of the incident and the resident was upset, tearful and distraught. Family member #2 reported the resident was so upset she was swearing which was not her usual behavior. The family reported the resident attempted to explain the incident to them while Staff #C was present and Staff #C interrupted the resident several times. Family member #2 was unsure why they were not contacted when the incident occurred and felt the situation warranted a call from the facility and	F 166		

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F 166	Continued From page 5 follow up of the outcome. The family member #2 reported that no one followed up with the family or resident when staff knew the resident was upset. Family shared the incident and concern with Staff #J several days after the incident when they heard nothing from the facility. Family member #2 stated the facility had not followed up as of 8/6/13. During an interview on 8/6/13 at 10:00 a.m., Staff #E stated if a resident was upset and an incident like this occurred then the social worker would be notified. Staff #E stated they were not notified about the incident until 8/5/13. Staff #E stated when they had a brief conversation with staff about the incident, the staff did not feel the resident was upset enough to report to social services. Staff #E stated that Staff #C and Staff #D were directly working with the resident the day of the incident and Staff #F was the charge nurse on duty. Staff #E stated if a staff member was no longer supposed to work with a specific resident it would be communicated in the morning meeting. Staff #E stated most of the communication was done verbally. Upon record review of Resident #2's chart, there was no documentation that provided any information or communication in regards to the incident and no documentation of follow up with resident or family. The facility did not acknowledge the severity of the incident for the resident. There was no inquiry with the resident or family in regards to the incident. The facility did not have a system to identify the need of the resident since they did not speak to the resident or family members to understand what had happened and once the	F 166		

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F 166	Continued From page 6 facility was informed there was no follow up with resident or family. There were no prompt efforts to resolve the grievance and a lack of communication from staff to identify residents needs.	F 166		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to promote an environment that maintains the resident's dignity for 1 resident (#2) in a sample of 28 residents, by not listening to the resident express her needs, personal preferences and unable to refrain from demeaning practices. Findings include: During an interview on 7/31/13 at 3:20 p.m. the resident reported she did not feel she was being treated with respect and dignity. The resident reported she was upset with an interaction between her and a nursing aide who assisted her in getting dressed a week prior. The resident reported the nursing aide provided her with a pair of pants from her closet and she told the nursing aide they were not her pants. The nursing aide continued to put the pants on the resident which were too tight and ended up ripping. The resident stated the nursing aide said "You will have to wear them this way" and the resident wore a blanket around her to cover the	F 241	F241 The nursing home will correct the deficiency as it relates to the resident and protect other residents in similar situations by educating, counseling, and taking appropriate disciplinary action with the employee involved. The facility will also re-in-service all staff regarding dignity and respect, as well as the new grievance policy and procedure. The facility will continue to label all residents' clothing to maintain resident dignity and respect of the individual and their clothing. This will be completed by 9/16/13. The	

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F 241	Continued From page 7 unfitting pants. The resident reported this did not make her feel she was being listened to and was hesitant to share incident with other staff since she felt they would not do anything about it. The resident reported multiple staff were aware of the incident. The resident reported there was no follow up after the incident had occurred. During an interview with Staff #E on 8/5/13 at 10:30 a.m., Staff #E stated the resident had complained about staff not listening to her on different occasions. During an interview on 8/5/13 at 1:45 p.m., Staff #C confirmed she had assisted the resident with dressing the day of the incident with the pants. Staff #C reported the pants that were put on the resident were too tight but so were her other pants. Staff #C reported after the resident soiled her pants she took other pants from the resident's dirty laundry bag to dress the resident. Staff #C reported the resident said they were not her pants and Staff #C informed the resident they were her pants. Staff #C reported she continued to work with the resident. During an interview on 8/5/13 at 2:15 p.m., Family member #1 reported she had returned a call to a nurse days after the incident in regards to another issue and asked the nurse what the outcome of the incident would be. The family member #1 reported the nurse told her the nursing aide will no longer work with the resident due to the pants incident and the roommates ripped pants would be replaced. During an interview on 8/6/13, Family member #2 reported she came to visit the resident the day of the incident and the resident was upset, tearful	F 241	Director of Nursing is responsible to ensure the correction.	

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F 241	Continued From page 8 and distraught. The family reported the resident attempted to explain the incident to the family and Staff #C interrupted the resident several times. The family reported there were 4 more clean pairs of pants in the closet and the resident stated she felt her choices are being taken away. The family reported she saw the ripped pants that were not the resident's in a bag labeled too small and looked at the pants tag which had the roommates name on it. During an interview on 8/6/13 at 10:00 a.m., Staff #E stated they were not notified about the incident until 8/5/13 when it had occurred a week prior. Staff #E stated staff she had spoke to did not feel that the resident was upset enough to report to social services. Staff #E stated that Staff #C and Staff #D were directly working with the resident the day of the incident and Staff #F was the charge nurse on duty. Staff #E stated if a staff member was not to work with a resident any longer it would be communicated in the morning meeting. The facility staff's interactions with the resident made the resident feel she was not being treated with respect and dignity since the staff did not listen to the resident when she said the pants were not hers and they did not fit. The resident was left with feeling that her personal preferences and choices were not being heard and staff do what they want.	F 241	F250 The nursing home will correct the deficiency as it relates to this	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial	F 250		

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F 250	Continued From page 9 well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to provide social service interventions for 1 of 3 residents (#36) reviewed for social services in a sample of 27 related to emotional support and adjustment. Findings include: Resident # 36 was admitted on [redacted]2011 with diagnoses including [redacted] he was alert, oriented and able to make needs known. The resident's current care plan for behavior, mood and well-being stated " I have a great outlook on life not too much gets me down I am realistic about my future I am an active member of Riverview community". Staff were to monitor resident for unusual changes in his mood with a goal to maintain his positive outlook and to feel comfortable at the facility. Per record review the resident was put on alert charting for 72 hours after the death of his roommate 3/27/13. A Nursing note dated 3/27/13 stated the resident had lost his roommate and didn ' t know what he would do if he lost his son. Per nursing note dated 3/28/13 it was noted the resident was sad about roommate ' s death. The resident was taken off alert charting with no additional interventions or follow up to meet his social service needs. Per record review the resident was again put on alert charting for 72 hours after a roommate change 4/19/13. A nurse note dated 4/19/13 documented the resident was awakened by the	F 250	resident and protect other residents in similar situations by creating a new communication form for our staff to fill out to inform our social service department of needs to be addressed. The facility will in service all staff on the new practice. In addition, the facility will have a social service progress note section in the new electronic chart. This will allow the facility to compare social service progress notes with the newly created communication forms to ensure that all residents' needs are being met. This corrective action will be completed by 9/16/13. The Director of Nursing will be responsible to ensure the correction.	

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F 250	Continued From page 10	F 250		

roommate ' s preparations for bed and was concerned about the noise in the morning. A nurse note dated 4/20/13 noted he had stated some disturbed sleep last night. Resident was taken off alert charting with no additional interventions or follow up to meet his social service needs.

During an interview on 8/1/13 with the resident, he was asked if there were problems with his roommate or other residents he stated yes, his roommate took a long time in the morning and it bothered him. When asked to clarify he was unable to express more details.

On 8/5/13 at 1:00 p.m., the resident was observed speaking with Staff #F (a nursing staff member) regarding concerns with his roommate ' s fall mat that had been newly placed.

Per interview with Staff #F on 8/6/13 at 9:40 a.m., she stated she had communicated the resident ' s concerns to Staff #T in the social services department.

Per interview on 8/6/13 at 9:50 a.m., Staff #T stated she didn ' t know anything specific regarding the resident today but was aware that he had been unhappy for a while about his room situation. She stated she had talked with the resident but was unable to recall any specifics and had not charted any visits or interventions for the resident.

Per an interview on 8/6/13 at 10:10 a.m., the resident stated he didn ' t feel good about his room situation and no one from the facility had talked to him about it, but he heard he may be moved to a new room soon. He stated the loss of his roommate and the room changes had been big adjustments and it wasn ' t' over yet.

The facility was aware of the resident ' s adjustment issues related to loss of roommate, room change and a new roommate, but failed to

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F 250	Continued From page 11 provide interventions and ongoing support for resident ' s emotional needs.	F 250		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441	F441 The nursing home will correct the deficiency as it relates to the resident and protect other residents in similar situations by updating our glucometer cleaning policy and procedure. The facility wll re-in service licensed nursing staff on the newly updated policy and procedure. The facility will also conduct glucometer infection control audits every week for four weeks to ensure that the new practices are being conducted throughout the facility. This will be completed by 9/16/13. The Director of Nursing will be responsible to ensure the correction.	

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F 441	Continued From page 12 infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure proper infection control standards were followed related to glucometer cleaning for 3 residents (#5, 30, 150) in the south hall. Findings include: 1. During medication administration on 7/31/13 at 11:40am & 11:50am, Staff #J completed blood sugar testing on Resident #5 and #30. The licensed nurse did not clean the glucometer (blood sugar monitoring device) prior to, following, and/or in between resident use. During an interview with licensed nurse on 8/1/13, she verified that she had not cleaned the equipment properly per infection control standards and facility policy. 2. During an observation of glucometer testing on 8/6/13 at 11:05 a.m., Staff #K did not clean the glucometer after use with Resident #5. At 11:25 a.m, Staff #K completed glucometer testing with Resident #115 and cleaned the glucometer with an alcohol wipe (not an approved agent for an object that may touch skin that is not intact.) At 11:50 a.m., Staff #K returned to the medication cart after completing glucometer testing with Resident #30 with the glucometer in his scrub pocket (potentially contaminated area). during interview at that time, he stated the procedure for disinfecting a multiple use glucometer was to clean with alcohol wipes after	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505291	A. BUILDING _____ B. WING _____	08/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 13 each use. The failure to clean the glucometer after each resident use with a proper disinfecting agent placed residents and staff at risk for transfer of infection.	F 441		